Assessment of the structure and function of the therapeutic abortion committee

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While the ethics and philosophy of the abortion question have been debated in every media and by every conceivable group, the mechanics of obtaining an abortion in Canada is a subject that, until recently, has been much ignored (see box below). The therapeutic abortion committee is legally designated with respect to the consideration of applications for abortions. The presence of this institutional barrier to abortion raises a number of questions, that must, in the light of the public concern about this subject, be considered. This article will not attempt to enter the abortion debate, the most explosive medicolegal problem of our time; it will consider only issues relevant to the status and function of the therapeutic abortion committee.

In 1969 changes were made in the Criminal Code of Canada pertaining to therapeutic abortions. These changes were made in an attempt to improve the existing laws. Prior to these changes, while therapeutic abortions were being carried out, some legal scholars argued that no abortion was truly legal under the law.[1] Section 251 (formerly section 237) is now the law covering therapeutic abortions. (See box on following page.)

Several procedural points are worthy of mention. The Criminal Code requires only a majority vote but does not (in the opinion of certain hospital counsel) make it clear whether it is a majority of the members appointed or a majority of the members attending a specific meeting. This may seem to be a small point, but the probability of an application's being successful or not may depend upon the interpretation of this subsection. Also, there is no provision for appeal in the present law. In a review of 10 hospital committees in Toronto and Winnipeg, Smith and Wineberg[2] found that the law is interpreted in a varied fashion and that an unsuccessful application at one hospital might be successful in another. They found that some hospital committees attempted to keep their abortion rates down to levels acceptable to their boards of governors. These authors suggested that an appeal mechanism might make the law more equitable.

The philosophy of the 1969 change in the Criminal Code as it pertains to the therapeutic abortion committee seems uncertain. It leaves the question of the termination of pregnancy entirely to the wisdom of the therapeutic abortion committee as this committee interprets the law and the situation of the individual applicant. The introduction of the therapeutic abortion committee (a departure from the pre-1969 legislation) was perhaps intended as a compromise, on one hand placating those who believe abortion is a legitimate medical procedure, while not totally offending those who feel it should at least be strictly limited or controlled. Thus the existence of this compromise must in the final analysis find itself on an ambiguous philosophical basis. A major area of ambiguity, and one that perfuses and permeates the routine function of this committee, is the question of the legal criteria for abortion.[2,3] Specifically, the legislation states that for a therapeutic abortion the individual's life or health must be threatened. Imprecision over the meaning of the term "health" has led to many difficulties. Most therapeutic abortion committees adhere to a broad definition of health, meaning the state of being sound in body and mind. Since adverse social and economic conditions, as well as medical and psychiatric illnesses, influence our general wellbeing, these multifactorial influences are considered valid by most members of most therapeutic abortion committees. However, this question will continue to be debated as long as the law lacks clarity.

Another problem, stemming directly from the ambiguous 1969 abortion provision, is the regional inconsistency. Each hospital may determine (through its elected board) whether or not to have a therapeutic abortion committee. Thus, patients legally entitled to apply for a therapeutic abortion may have to travel to another hospital or another community in order to reach this service. This situation in some areas is commonplace, and it places the burden of establishing contacts with new physicians in strange hospitals, under the pressure of time, on a usually anxious human being. Occasionally physicians respond to this basic unfairness by bypassing the therapeutic abortion committee. For example in 1975 Quebec had 35 hospitals with therapeutic abortion committees vs. 110 in Ontario and in 1975, 24 921 legal abortions were performed in Ontario and 5579 were performed in Quebec.[4]

Another area of inconsistency, flowing directly from the lack of clear philosophy of the abortion provisions of the Criminal Code, is the underlying

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Although my report was written prior to the publication of the Badgley committee report on the operation of the abortion law, the Badgley committee confirmed most of the findings described in this paper and, in fact, documents many inequities in the abortion law. In my view, future debate in this area will centre on the question of whether the law is satisfactory and only its application is faulty (the view put forward by the Badgley committee) or, whether the inequities in the abortion process stem inevitably from an ambiguous and unsatisfactory law. I believe the evidence demonstrates that the law itself is the cause of most of the problems described in my report and that of the Badgley committee.

subjectivity of members of the individual therapeutic abortion committee. No matter how carefully and intelligently each committee member reviews applications for abortions, his decisions are based on the facts documented by physicians applying on behalf of their patients and on his own religious and philosophical beliefs. It is extremely difficult to judge how deleterious a patient's adverse social or economic situation must be in order to injure her health. Since in most instances there is no personal or written exchange between the therapeutic abortion committee and the applicant, to an extent the success of any application may depend on the skill with which it is presented by the referring physician. Obviously, the conscientious member of the therapeutic abortion committee must find it difficult to examine each application then adjudge it in a consistent fashion. Many studies have been done on the psychiatric indications for abortion. However, the rejection of an applicant for therapeutic abortion has attendant risks that must be understood. In a 7½-year follow-up study by Hook[5] of the psychological adjustment of 294 women who were refused an abortion, adjustment was markedly impaired in 24% of the women, 53% had eventually and with difficulty adjusted and only 24% were well adjusted at the end of this period of study. Furthermore, criminal abortions have been shown to be more common in women who have been denied a therapeutic abortion.[6] These factors emphasize the great significance of the decision made by the therapeutic abortion committee.

The accessibility of the committee to the individual is a real problem for many patients. In the Smith and Wineberg survey,[2] hospitals varied in their requirements, but most required two letters of concurrence before the application could be presented to a therapeutic abortion committee. Clearly, the sophisticated patient with an understanding family doctor is more likely to have an advantage in acquiring the needed documents.

The mechanics of the therapeutic abortion committee as an institutional bureaucracy are worth scrutiny. One difficulty is the delay this committee must cause in the application process. Although most committees meet frequently (usually weekly), this results in an inevitable delay in a situation where delay tends to increase the risk of the procedure. Patients whose applications are rejected may be dangerously close to the 2nd trimester of pregnancy and may continue to search for a legal abortion, a situation perilous to maternal safety.

In addition to delay and problems with access, many therapeutic abortion committees have become extremely cautious in approving applications for abortion, due to recent attacks upon these committees by anti-abortion groups and elected members of the government. This fear and caution is well-founded, since the possibility has been raised that therapeutic abortion committee members may be prosecuted for infractions of the abortion provisions of the Criminal Code, although this possibility is at present unlikely. However, since the penalty is defined as up to life imprisonment, and since the exact potential infractions have not been precisely defined nor tested in the courts, it is understandable that members of this committee may be reluctant to approve some applications in the present atmosphere. (In fact, no judicial or quasijudicial body, with the exception of the therapeutic abortion committee, can be, even potentially, held similarly accountable for "incorrect" decisions.) I am, for example, aware of instances in which therapeutic abortion committee members have, in fact, been investigated for their activities as part of this committee. I have been unable to obtain legal opinion which would definitely rule out the possibility of a criminal action against committee members. This atmosphere is clearly antithetic to the original intent of the law, which was, apparently, to create the therapeutic abortion committee as a rational and unbiased body of adjudication. Thus, unwillingly, the therapeutic abortion committee has been driven into the larger abortion battlefield, a position it was never intended to occupy.

Around the world, the situation is as confused as it is within Canada.[7,8,9] Many countries require some form of hospital screening committee, or at least the concurrence of a second consulting physician, prior to abortion. For example, in France, prior to 1974, legal abortions were difficult to obtain. Now women can obtain an abortion before 10 weeks gestation if they

Selected clauses of the Criminal Code

251. (1) Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable to imprisonment for life.

(2) Every female person who, being pregnant, with intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years.

* * *

(4) Subsections (1) and (2) do not apply to

(a) a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital, who in good faith uses in an accredited or approved hospital any means for the purpose of carrying out his intention to procure the miscarriage of a female person, or

(b) a female person who, being pregnant, permits a qualified medical practitioner to use in an accredited or approved hospital any means described in paragraph *(a)* for the purpose of carrying out her intention to procure her own miscarriage,

if, before the use of those means, the therapeutic abortion committee for that accredited or approved hospital, by a majority of the members of the committee and at a meeting of the committee at which the case of such female person has been reviewed,

(c) has by certificate in writing stated that in its opinion the continuation of the pregnancy of such female person would or would be likely to endanger her life or health, and

(d) has caused a copy of such certificate to be given to the qualified medical practitioner.

* * *

(6) For the purposes of subsections (4) and (5) and this subsection

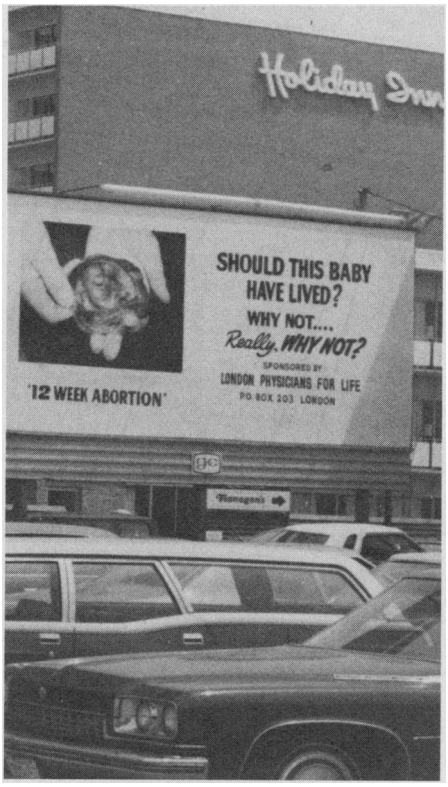
"accredited hospital" means a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical and obstetrical treatment are provided;

"approved hospital" means a hospital in a province approved for the purposes of this section by the Minister of Health of that province;

* * *

"therapeutic abortion committee" for any hospital means a committee, comprised of not less than three members each of whom is a qualified medical practitioner, appointed by the board of that hospital for the purpose of considering and determining questions relating to terminations of pregnancy within that hospital.

attend a special counselling service. If greater than 10 weeks gestation they can obtain an abortion only for severe medical indications with the concurrence of a second physician. In the USSR a woman may obtain a legal abortion if she is less than 12 weeks pregnant and can obtain a certificate from a local medical officer that a pregnancy exists.[10,11] In Yugoslavia, commissions established by approved hospitals, consisting of two doctors and a social worker, decide on each case by majority vote using guidelines similar to the Canadian guidelines.[10] Japanese law prior to 1948 required medical screening boards, but this requirement was deleted in legislation passed in 1948. In Japan, legal abortions may now be obtained on demand.[11] The presence of hospital screening committees and a legal limit of 12 weeks for legal abortions does not prevent Hungary from having one of the highest abortion rates in the world (122.8 per 100 live births, 1973).[10,11] The similarities of most commonwealth countries' abortion laws are remarkable and undoubtedly flow from the landmark R. vs. Bourne decision of 1938. In this decision, Mr. A. Bourne, an eminent British gynecologist, openly performed an abortion on a 14-year-old girl who had been raped, on the grounds that the pregnancy would endanger her mental health. The judge agreed that if continuation of the pregnancy would make the woman a physical and mental wreck, then it was legal to terminate the pregnancy on the grounds that in a general sense the life of the mother was being preserved. This great precedent, with its numerous implications, has influenced the laws in many commonwealth countries. Now, in the United Kingdom (excluding Northern Ireland), legal abortions may be obtained in approved centres if two physicians agree the pregnancies would adversely affect the life or health of the women or the children of the women.[11] South Australia, India and Zambia, for example, require approval of two physicians.[12] Most Commonwealth countries limit abortion from 20 to 28 weeks gestation. Most commonwealth countries allow physical health, mental health and socioeconomic reasons as grounds for abortion. It is apparent that many countries (with mainly their commonwealth affiliation in common and with wide social and religious differences) rely on medical screening committees to determine legality of therapeutic abortions. It is interesting to note that some countries (Canada is an exception) recognize fetal abnormality (or the likelihood thereof) as an indication for therapeutic abortion.



Protection of fetus. Symbolic?

The American situation is worth examining in some detail.[13] Up to the historic 1973 Supreme Court decision (Wade vs. Roe, Doe vs. Bolton), the laws of the individual states were chaotic and confusing. In many states, statutes requiring hospital screening committees or second opinions were strictly enforced, and many states had highly restrictive legislation. In 1973 the US Supreme Court ruled (in part):

- The states may not regulate abortions during the 1st trimester of pregnancy.
- During the 2nd trimester the states may regulate abortions with regard to the protection of maternal safety.
- Past the 2nd trimester, at about the 28th week of gestation (the approximate time of potential fetal viability) the states may regulate abortion in order to protect and preserve potential human life.
- The states may not require by statute the concurrence of other physicians or hospital screening committees.

At a stroke, the highest US court thus essentially permitted abortion on demand up to the 3rd trimester, did away with constraints such as abortion committees and brought to the fullest extent possible, within its power, uniformity in the law throughout the US.

The therapeutic abortion committee in Canada, as elsewhere, appears in my opinion to be society's proxy in its attempt to recognize and affirm the sanctity of life of the fetus. This form of protection is symbolic. It is not effective practically, since the therapeutic abortion rate has been increasing yearly. In another sense, this committee system is counterproductive, since the inconsistencies documented in this article and the ambiguities of the law tend to result in indignity to the female applicant. In addition, the criminal statutes are harsh and potentially discriminatory to the medical personnel who donate their time to serve on these committees. The present abortion statutes are thus ambiguous and unfair and should be clarified. With specific reference to the therapeutic abortion committee, it is my contention that this committee system should be abandoned. A system more closely resembling the new American abortion laws would serve the needs of our society and do away with many of the inequities documented in this article.

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